

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8569

Registration District No. 1

Primary Registration District No. 4549

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Wright
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether
In this community two weeks years, months or days)

3. (a) PRINT
FULL NAME

8. (b) If veteran,

3. (c) Social Security

name war

No.

4. Sex M

5. Color or
race W

6. (a) Single, widowed, married,
divorced married

6. (b) Name of husband or wife Bella Epperly

8. (c) Age of husband or wife if
alive 76 years

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

86

1

19

hr.

min.

9. Birthplace

(City, town or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County
(c) City or town Ottumwa
(If outside city or town limits, write "RURAL")
(d) Street No. B. 3
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3
year 1940 hour 10 minute 5 9 M.

21. I hereby certify that I attended the deceased from 2/2 to 2/3 1940
that I last saw him alive on 2/2 and that death occurred on the date and hour stated above.

Immediate cause of death

cerebral apoplexy

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)
(b) Means of injury

23. Signature R. A. Ryan (M. D. or other)
Address Wright Date signed 3-4-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 6,

District File Number 340-8837

Date Filed MAR 15 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. 3161

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.